PATIENT HISTORY

Last _____ First _____ Middle Initial _____ Date of Birth _____

Address _____ City _____ST_____ Zip _____

Phone (H) _____ (W) _____ (C) _____

Email _____ Emergency Contact & Phone _____

Your Occupation _____Your Employer _____

Insurance Coverage? Yes ☐ No ☐ **Please provide insurance card/cards**

Policy Holder's Name_____ PH Employer _____PH DOB_____

Do you have a Secondary or Supplemental Insurance? Y N Policy Holder's Name _____PH DOB _____

Spouse/Guardian Name _____Sp/Gu DOB _____Sp/Gu Employer: _____

Who may we thank for referring you to this office?_____

Main Problem

Is this problem work or auto accident related? _____

What pain or symptom causes you to come to our office? _____

What caused the pain? _____

When did this pain start? _____ Did the pain begin: ☐ Gradual ☐Sudden ☐Progressive over time

How bad is this pain? (Circle the one that applies) Mild Moderate Severe Intolerable

How often does this the pain occur? (chwck box that applies) (Occasional) ☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100% (constant)

Circle the word or words that best describe your pain. Cramping, Aching, Dull, Sharp, Shooting, Bright, Diffuse, Lightinglike, Throbbing, Nagging, Burning, Deep, Stinging, Pressurelike

Does this pain travel to any other area? _____

What makes this pain better? _____

What makes this pain worse? _____

Have you been to anyone else for this problem? ☐yes ☐no Who_____Treatment_____

What else have you done to treat this pain? _____

Rate the intensity of the pain on scale of 0-10 (0 being no symptoms, 10 being extreme) Best _____ Worst _____

Any Other Problem

What other pain do you have? _____

What caused the pain? _____

When did this pain start? _____ Did the pain begin: ☐ Gradual ☐Sudden ☐Progressive over time

How bad is this pain? (Circle the one that applies) Mild Moderate Severe Intolerable

How often does this the pain occur? (Circle the one that applies) Occasional Frequent Constant

Circle the word or words that best describe the pain. Cramping, Aching, Dull, Sharp, Shooting, Bright, Diffuse, Lightening-like, Throbbing, Nagging, Burning, Deep, Stinging, Pressure-like

Does this pain travel to any other area? _____

What makes this pain better? _____

What makes this pain worse? _____

Have you been to anyone else for this problem? ☐yes ☐no Who_____Treatment_____

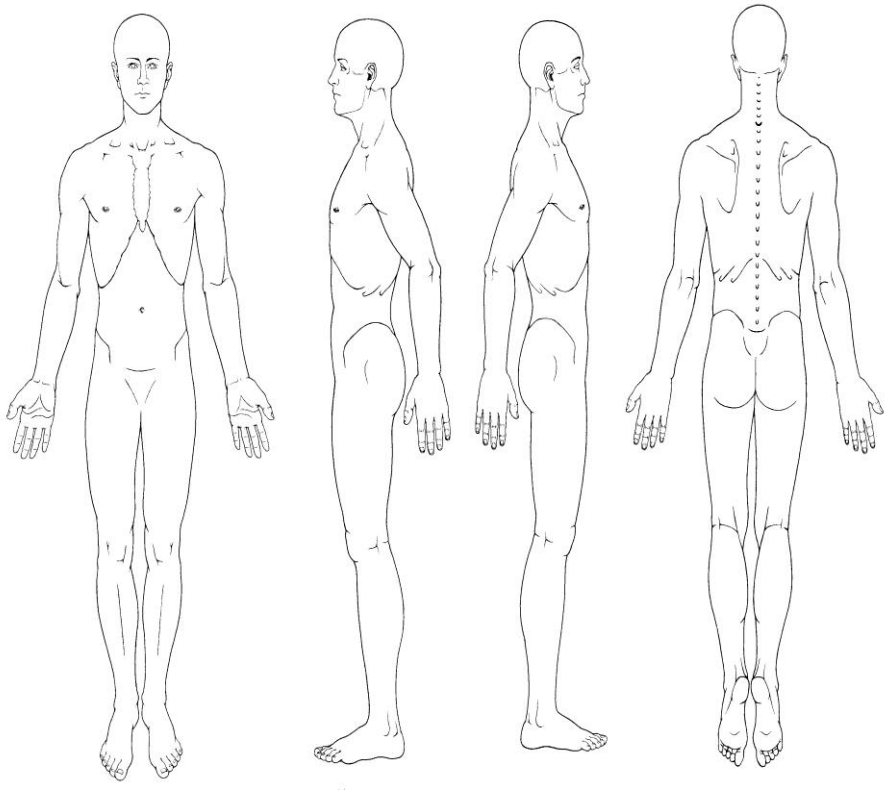
What else have you done to treat this pain? _____

Rate the intensity of the pain on scale of 0-10 (0 being no symptoms, 10 being extreme) Best _____ Worst _____

PATIENT SIGNATURE _____ **DATE** _____

Please mark off the areas of your complaint on the diagram with the following indicators:

PPP = pain
NNN = numbness
TTT= tingling
BBB= burning
CCC= cramping
XXX = other



Physical History

List any broken bones (fractures) or dislocations _____

Ever on crutches? **Y N** Why? _____

Ever had spinal tap, epidurals or other spinal injections? **Y N** Why? _____

Ever knocked unconscious? **Y N** Lapse in memory? **Y N**

Ever worn braces? **Y N** Any other extensive dental/orthodontic work? **Y N**

Ever had x-rays taken? **Y N** Why? _____

List any accidents, Injuries, or falls and the dates when occurred _____

_____

Chemical & Social History

Do you exercise? **Y N** If yes, how many times per week and what type? _____

Do you have a high stress level? **Y N** If yes, list reasons:_____

_____

Are you presently taking any prescription or over-the-counter medication? **Y N** Please list, and reason for taking _____

_____

_____

PATIENT SIGNATURE _____ **DATE** _____

PAST HISTORY

It is important for the doctor to know of your past history. Please check all that apply to your past medical history.

Please check all of the following that apply to you:

☐ Alcohol/Drug Dependence
☐ Recent Fever
☐ Diabetes
☐ Headache
☐ Stroke (date) _____
☐ Corticosteroid Use (Cortisone, Prednisone, etc.)
☐ Taking Birth Control Pills
☐ Dizziness/Fainting
☐ Numbness in Groin/Buttocks
☐ Numbness or pain in arms/legs/hands
☐ Loss of sleep
☐ Cancer/Tumor (Explain) _____
_____
☐ Tobacco Use – Type_____ Frequency_____/Day
☐ Epilepsy/Seizures
☐ Digestive Problems
☐ Prostate Problems
☐ Menstrual Problems
☐ High Blood Pressure
☐ Fatigue
☐ Abnormal Weight ☐ gain ☐ loss
☐ Marked Morning Pain/Stiffness
☐ Pain Unrelieved by Position or Rest
☐ Pain at Night
☐ Visual Disturbances
☐ Osteoporosis
☐ Night Sweats
☐ Currently Pregnant, # weeks _____

Surgeries_____

Is there any other condition or health factor not previously shared that you wish to discuss? _____
_____
_____

Family History

Has anyone related to you ever been diagnosed with (use key below)

M - Mother F - Father S - Sibling

___ Heart Problems/Stroke ___ Bone Disease (such as Rheumatoid Arthritis) ___ Cancer
___ Auto-immune disorder ___ Diabetes

PATIENT SIGNATURE _____ **DATE** _____